NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) TAG DEFICIENCY) DATE	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155230		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/12/2012	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			ER	2050 C	CHESTER BLVD	
F0000	PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
This visit was for the Investigation of Complaint IN00106389. Complaint IN00106389 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, and F328. Survey dates: April 11 and 12, 2012 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Survey team: Barbara Gray RN TC Sharon Lasher RN Census bed type: SNF/NF: 60 Total: 60 Census payor type: Medicare: 9 Medicare: 9 Medicare: 9 Medicarid: 45 Other: 6 Total: 60 Sample: 5 These deficiencies and federal law by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirement under state and federal law. Please accept this as our credible allegation of compliance.*** To Plan of Correction of the statement of deficiencies. The Plan of Correction of compliance.*** The Plan of Correction is prepared and submitted because of requirement under state and federal law. Please accept this as our credible allegation of compliance.*** Survey team: Barbara Gray RN TC Sharon Lasher RN Census bed type: SNF/NF: 60 Total: 60 Census payor type: Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 9 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Complaint IN00 Federal/state de allegations are of F328. Survey dates: A Facility number Provider number AIM number: Survey team: Barbara Gray R Sharon Lasher II Census bed type SNF/NF: 60 Total: 60 Census payor ty Medicare: 9 Medicaid: 45 Other: 6 Total: 60 Sample: 5 These deficience	20106389. 20106389 - Substantiated. 20116389 - Substantiated. 20106389	F0000	Correction does not constitut admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The Plan of Correction is prepared and submitted becar of requirement under state and federal law. Please accept the as our credible allegation of compliance.***Based upon resofthis Plan of Correction, ple consider the Plan of Correction.	he n on . ause nd nis eview ease

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000135

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 12/2012		
	PROVIDER OR SUPPLIER JD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	Quality review 4/19/12 by Suzanne Williams, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 2 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155230	B. WING			04/12/	2012
	ROVIDER OR SUPPLIER			2050 CH	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD DND, IN 47374		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	 	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	1	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA (INJURY/DECLII A facility must im resident; consult and if known, not representative or member when th the resident whice the potential for r intervention; a sig- resident's physical status (i.e., a det or psychosocial status (i.e.,	NE/ROOM, ETC) Imediately inform the with the resident's physician; tify the resident's legal an interested family ere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, status in either life itions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as a.12(a). also promptly notify the mown, the resident's legal interested family member					
	assignment as space change in resident State law or regular paragraph (b)(1) The facility must	record and periodically					
	resident's legal re family member.	ess and phone number of the epresentative or interested	7017				0.4/2-7/2-2-2
	facility failed to a family when residue. C-PAP (continuo	ew and record review, the notify the physician and dents refused to wear ous positive airway P(bilevel positive airway	F0157		F-157 A facility must inform the resident; consult with the MD, notify the resident's lega representative or an intereste family member when a reside requires a need to alter	il ed	04/27/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 3 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	TED
		155230	B. WIN			04/12/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			HESTER BLVD		
ROSEBI	JD VILLAGE				OND, IN 47374		
			1				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		ered, for 2 of 4 residents			treatment significantly. 1. Resident C has since been		
	reviewed for C-PAP/Bi-PAP in a sample of 5. (Resident #C and #A) Finding include:				discharged to home from the		
					facility. Resident A's physiciar	n	
					and family have been notified		
					the resident's history of refusa		
					wear the Bi-Pap as ordered. 2		
	1.) The record of	of Resident #C was			All residents who utilize C-Pap	or	
	l '	1/12 at 1:25 p.m.			Bi-Pap machines have the potential to be affected. A revi	iow/	
	23,12,,34 on 1/1	av 1.20 p			of those residents' records has		
	Dagidant #C'a nh	vaision's reconitulation			been completed and no other		
	Resident #C's physician's recapitulation				concerns were noted. (See		
	· ·	2, indicated "oxygen at 6			attachment 1) 3. All nurses w	rill	
	1	izer (oxygen conserving			be in-serviced by the DNS or h		
	·	AP with setting of 6 use			designee by April 27, 2012 on		
	at HS (bedtime).				informing the physician and the resident's responsible party	e	
					immediately should a resident		
	Resident #C's nu	irsing notes indicated the			refuse to wear their ordered		
	following:				C-Pap or Bi-Pap devices. The	,	
		a.m., "resident refused			charge nurse will monitor		
		stated 'it makes me feel			residents daily on all shifts to		
		was educated on reasons			ensure residents are using the	;	
	•	wear it. She said she			C-Pap or Bi-Pap machine as ordered by their physician and	, add	
	_				document in the Treatment	WIII	
	knows but doesn				Record. If the resident refuses	s to	
		a.m., "resident refused			use the C-Pap or Bi-Pap		
	_	tating that she is ok with			machine, the resident's physic		
	l -	2 on via nasal cannula 6			and family will be notified. (Se		
	liters in place."				attachment 2) 4. The DNS or		
	- 4/9/12 at 1:30 a	a.m., "resident on 6 liters			her designee will monitor treatment sheets and nurses		
	02 via nasal can	nula, refused C-PAP			notes daily on scheduled days	of	
	tonight."				work, on varying shifts, for 4		
					weeks; then 3 times per week,	on	
	The clinical record lacked evidence the resident's physician or family was notified				varying shifts, for 4 weeks; the		
					monthly, on varying shifts, for		
					months; and then quarterly, or		
	of Kesident #C r	efusing her C-PAP.			varying shifts, until compliance maintained for 2 consecutive	e is	
l			\perp		maintained for 2 consecutive		

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	LDING	ONSTRUCTION 00	(X3) DATE COMPL 04/12 /	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	p.m., Resident #6 indicated Reside problem with the provided and has C-PAP since she The family mem that her C02 (car up or with her sle stop breathing from achine." During an interval. Resident #6 used a C-PAP the facility becaused her C-PAP After the first nigher to send her Couse the C-PAP me furnished. She is machine the facility work. It made he did not feel like soxygen at all. Resident with that wear it." During an interval. During an interval. The problem is to hook the C-PAP increased to wear it to hook the C-PAP.	cew on 4/11/12 at 3:00 C's family member int #C is having a cC-PAP the facility not been able to use a came into the facility. ber stated, "I am worried bon dioxide) might build eep apnea she might just om not using the C-PAP dew on 4/12/12 at 9:30 C indicated she had only e first night she was in use the first night she machine from home. In the facility instructed cPAP machine home and machine the facility indicated the C-PAP Lity furnished did not her feel afraid because she he was receiving any he sident #C stated "I have he wery evening that I can't C-Pap and I just can't The won 4/12/12 at 9:50 Licated Resident #C had her C-PAP when she tried her up at 9:00 p.m., a few he was resident #C did not her cause Resident #C did not		quarters for those residents we utilize C-Pap or Bi-Pap device ensure that the residents are using them as ordered and, if notification to the physician are family has been made. (See attachment 3)To ensure compliance, the audits will be reviewed by the Continuous Quality Improvement Committoverseen by the Executive Director, during the montly meeting for 6 months or until compliance is maintained for a consecutive quarters. 5. The above corrective measures with completed on or before April 2 2012.	not, and eee,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 5 of 20

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		04/12/2012
NAME OF I	PROVIDER OR SUPPLIE	B		ADDRESS, CITY, STATE, ZIP CODE	
				CHESTER BLVD	
ROSEBU	JD VILLAGE		RICHN	10ND, IN 47374	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ting any oxygen. LPN #1			
	stated "I told her she was getting oxygen."				
	During an interview on 4/12/12 at 10:45				
	1	licated she was not aware			
	_	th Resident #C's C-PAP			
		told her today, and the			
		vns the C-PAP are			
		ay to check Resident #C's			
	C-PAP machine.				
	2.) Resident #A	's record was reviewed on			
	4/11/12 at 2:00 l	P.M. Diagnoses included			
	but were not lim	ited to respiratory failure,			
	chronic obstruct	ive pulmonary disease			
	(COPD), hypoxi	ia, right upper lobe lung			
	nodule, and anxi				
	,	, and the second			
	Resident #A's qu	uarterly Minimum Data			
	-	dated 2/12/12, indicated			
		Resident #A had shortness			
		ble breathing with			
		ess of breath or trouble			
	1	sitting at rest, and			
	_	ath or trouble breathing			
	when lying flat.	and of alonois of summing			
	,, non ly mg nat.				
	A nurses note fo	or Resident #A indicated			
		8/6/12 at 8:00 A.M A			
		eceived for Resident #A			
	to receive Bi-level positive airway pressure (Bi-pap) therapy at night for 8				
		gen therapy would be			
	commued at 2.5	liters per minute via			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet Page 6 of 20

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155230	B. WIN			04/12/	2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			2050 CI	HESTER BLVD		
	JD VILLAGE				OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
		th sleep. The Bi-pap					
	•	be set at 14/6, with use of					
	heated humidifier. A large full face mask would be used and changed every 90						
		nd changed every 90					
	days.						
	A care plan for Resident #A indicated the following: Start Date: 3/6/12. Problem:						
		uired the use of Bi-pap					
	therapy at night for 8 hours due to a diagnosis of acute respiratory failure, COPD, bronchitis, and right upper lobe						
		proaches: Resident #A's					
	power of attorne	y (POA) would be					
	notified if Reside	ent #A refused to receive					
	her oxygen or B	i-pap therapy treatment.					
	Nurses notes for	Resident #A indicated					
	the following: 3	/20/12 at 10:00 P.M					
	The resident refu	used her Bi-pap therapy,					
	stating, "I think	I'm doing O.K. without					
	it."						
	3/21/12 at no tin	ne - The resident refused					
	her Bi-pap thera	py, stating, "my face was					
		were noted on her face.					
	3/21/12 at 9:00 I	P.M The resident					
	refused her Bi-pa	ap therapy, complaining it					
	_	able." There were no					
	signs of face irri	tation.					
	_	M The resident					
	continued to refu	ise her Bi-pap therapy,					
		ng my face stop hurting					
	_	enderness or redness was					
	noted.						
	I		ı				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet Page 7 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	COMPI	
AND PLAN	OF CORRECTION	155230	A. BUI	LDING	00	COMPL 04/12/	
		100200	B. WIN			04/12/	ZU 1Z
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DOSEDI	JD VILLAGE				HESTER BLVD		
	·		RICHMOND, IN 47374				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		P.M The resident	+	TAU			DATE
	received her Bi-p						
	refused to wear i	0 to 45 minutes, then					
		P.M The resident					
	received her Bi-p						
	it be removed.	5 minutes, then requested					
	3/25/12 at no tim	a. The regident					
		ise her Bi-pap therapy,					
	stating "I want to wait a few more days." No redness was noted on her face. 3/26/12 at 12:00 A.M The resident						
		ise her Bi-pap therapy,					
	indicating her fac						
		P.M The resident					
	•	nortness of breath. She					
		Oxygen saturation was					
		ent received a breathing					
		r oxygen saturation rose					
		ident continued to refuse					
		by and disregarded staff's					
		The resident appeared					
	calmer.						
		A.M The resident					
	refused her Bi-pa						
		A.M The resident was					
		y slow to respond. She					
		ic with pale skin. Her					
		n was 89% on 2 liter of					
		cannula. Her lung					
		inished bilaterally. An					
		ed to send the resident to					
	the emergency ro	oom for evaluation and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 8 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	COMPL		
ANDILAN	OF CORRECTION	155230	A. BUI	LDING	00	04/12/	
		155250	B. WIN			04/12/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEBL	JD VILLAGE				HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	treatment.						
	A local hospital	note for Resident #A					
	dictated on 3/28/	12 at 1:15 P.M.,					
	indicated the foll	owing: Chief					
	Complaint: The	resident was sent to the					
	emergency room	(ER) with breathing					
	difficulty. She w	vas obtunded in the ER					
		d yes or no to the					
	"	physician's questions.					
	"	Bi-pap therapy treatment.					
	_	aving more breathing					
		lay. Impression: "1.					
	Acute hypercapn	• •					
		Acute exacerbation of					
		ve pulmonary disease					
		7. Chronic hypoxia. 9.					
		"Induced sputum					
		nous steroid. DuoNeb					
		t. Intravenous antibiotic.					
		. Sliding-scale insulin					
		nue oxygen. Deep vein					
	thrombosis propl	nylaxis."					
		r Resident #A dated					
		P.M., indicated the					
		to the facility from a					
	local hospital.						
		on was available in					
	Resident #A's red	cord the resident's					
	physician or POA	A had been notified of her					
	repeated refusals	to receive her Bi-pap					
	therapy treatmen	t.					
	<u> </u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 9 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155230		00		
	PROVIDER OR SUPPLIER ID VILLAGE	2050 CI	ADDRESS, CITY, STATE, ZIP CO HESTER BLVD OND, IN 47374	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	An interview with the Assistant Director of Nursing on 4/12/12 at 1:33 P.M., indicated there was no documentation available in Resident #A's record, her physician or POA had been notified of her repeated refusals to receive her Bi-pap therapy treatment. This federal tag relates to Complaint IN00106389. 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 10 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	00	COMPLETED
		155230	A. BUILDING		04/12/2012
			B. WING	TADDRESS CITY STATE ZID CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD	
DOSEDI	JD VILLAGE			MOND, IN 47374	
KUSEBU	DD VILLAGE		RICH		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY CARE PLAN The services profacility must be in accordance we plan of care. Based on intervictable for Based on intervictable for Bi-paresidents review sample of 5. (Referring included Resident #A's referring included Resident #A's refer	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons with each resident's written iew and record review, the ofollow their plan of care ident's family of repeated ap therapy, for 1 of 5 oved for plan of care, in the sident #A) e: ecord was reviewed on P.M. Diagnoses included, nited to, respiratory obstructive pulmonary obstructive pulmonary obstructive pulmonary of the provided and anxiety. uarterly Minimum Data dated 2/12/12, indicated Resident #A had shortness able breathing with ess of breath or trouble sitting at rest, and ath or trouble breathing	F0282	F-282 The services provided or arranged by the facility metersons in accordance with each resident's written plant care. 1. Resident A's plan of care has been reviewed and changes were made. Resided A's physician and family have been notified of the resident's history of refusal to wear the Bi-Pap as ordered. 2. All residents who utilize C-Pap of Bi-Pap machines have the potential to be affected. A resident of those residents' records have been completed and no other concerns were noted. (See attachment 1) 3. All nurses of the been completed and no other concerns were noted. (See attachment 1) 3. All nurses of the been completed and no other concerns were noted. (See attachment 1) 3. All nurses of the been completed and no other concerns were noted. (See attachment 1) 3. All nurses of the properties of the plant care in regards to C-Pap and Bi-Pap devices with emphasis informing the physician and the resident's responsible party immediately should a resident refuse to wear their ordered C-Pap or Bi-Pap devices. The charge nurse will monitor dail all shifts to ensure residents a using the C-Pap or Bi-Pap machine as ordered by their	of fonce in the contract of th
		received for Resident #A		physician and will document in the Treatment Record. If the	n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet Page 11 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLET	ED
		155230		LDING		04/12/20)12
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DOOFDI	ID \				HESTER BLVD		
ROSEBU	JD VILLAGE			RICHIVI	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to receive Bi-lev	el positive airway			resident refuses to use the C-F		
	pressure (Bi-pap) therapy at night for 8 hours. Her oxygen therapy would be				or Bi-pap machine, the resider	nt's	
					physician and family will be	.	
	1	liters per minute via			notified. (See attachment 2) 4 The DNS or her designee will	' .	
		th sleep. The Bi-pap			monitor treatment sheets and		
					nurses notes daily on schedule	ed	
	•	be set at 14/6, with use of			days of work, on varying shifts		
		er. A large full face mask			for 4 weeks; then 3 times per		
	would be used an	nd changed every 90			week, on varying shifts, for 4		
	days.				weeks; then monthly, on varying	ng	
					shifts, for 3 months; then	4:1	
	A care plan for Resident #A indicated the				quarterly, on varying shifts, un compliance is maintained for 2		
	following: Start	Date: 3/6/12. Problem:			consecutive quarters for those		
	1	uired the use of Bi-pap			residents who utilize C-Pap or		
		for 8 hours due to a			Bi-Pap devices to ensure that		
					resident's plan of care has bee	en	
		te respiratory failure,			followed accordingly. (See		
		is, and right upper lobe			attachment 3) To ensure		
		pproaches: Resident #A's			compliance, the audits will be		
	power of attorne	y (POA) would be			reviewed by the Continuous Quality Improvement Committee	20	
	notified if Resid	ent #A refused to receive			overseen by the Executive	5 C ,	
	her oxygen or Bi	i-pap therapy treatment.			Director, during the monthly		
					meeting for 6 months or until		
	Nurses notes for	Resident #A indicated			compliance is maintained for 2	!	
		/20/12 at 10:00 P.M			consecutive quarters.5. The		
	_	used her Bi-pap therapy,			above corrective measures wil		
					completed on or before April 2	7,	
	_ ·	I'm doing O.K. without			2012.		
	it."						
		ne - The resident refused					
	her Bi-pap thera	py, stating, "my face was					
	sore." No areas	were noted on her face.					
	3/21/12 at 9:00 P.M The resident refused her Bi-pap therapy, complaining it was "uncomfortable." There were no signs of face irritation.						
	_	M The resident					
	3/22/12 at 12 A.	ivi The resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet Page 12 of 20

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 04/12 /	ETED
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET A	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD DND, IN 47374	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	stating "I'm letting first." No face to noted. 3/23/12 at 10:00 received her Bi-papproximately 30 refused to wear in 3/24/12 at 10:00 received her Bi-papproximately 13 it be removed. 3/25/12 at no time continued to refuse tating "I want to No redness was in 3/26/12 at 12:00 continued to refusing indicating her face 3/26/12 at 9:00 From complained of shappeared pale. On the state of the stat	O to 45 minutes, then t. P.M The resident cap therapy 5 minutes, then requested ne - The resident use her Bi-pap therapy, o wait a few more days." noted on her face. A.M The resident use her Bi-pap therapy, ce still hurt. P.M The resident nortness of breath. She Oxygen saturation was ent received a breathing or oxygen saturation rose ident continued to refuse by and disregarded staff's The resident a.M The resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 13 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155230	A. BUI	LDING	00	04/12/	
		133230	B. WIN			04/12/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEBUD VILLAGE					HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cannula. Her lung					
		inished bilaterally. An					
		ed to send the resident to					
		oom for evaluation and					
	treatment.						
	-	note for Resident #A					
	dictated on 3/28/	· · · · · · · · · · · · · · · · · · ·					
	indicated the foll	_					
	•	resident was sent to the					
		(ER) with breathing					
	_	vas obtunded in the ER					
	-	d yes or no to the					
		physician's questions.					
	_	Bi-pap therapy treatment.					
		aving more breathing					
		lay. Impression: "1.					
	Acute hypercapn						
		Acute exacerbation of					
		ve pulmonary disease					
		7. Chronic hypoxia. 9.					
		"Induced sputum					
		ous steroid. DuoNeb					
		t. Intravenous antibiotic.					
		. Sliding-scale insulin					
	_	nue oxygen. Deep vein					
	thrombosis propl	nylaxis."					
	A nurses note for	r Resident #A dated					
	3/31/12 at 5:30 P	P.M., indicated the					
		to the facility from a					
	local hospital.						
	No documentation	on was available in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 14 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155230	(X2) MULTIPLE CC A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER JD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	Resident #A's record the resident's POA had been notified of her repeated refusals to receive her Bi-pap therapy treatment.						
	An interview with the Assistant Director of Nursing on 4/12/12 at 1:33 P.M., indicated there was no documentation available in Resident #A's record, her POA had been notified of her repeated refusals to receive Bi-pap therapy treatment. This federal tag relates to Complaint IN00106389. 3.1-35(g)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 15 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155230		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE COMPL 04/12	LETED	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			205	EET ADDRESS, CITY, STATE, ZIP COD 0 CHESTER BLVD HMOND, IN 47374	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	CROSS-REFERENCED TO THE APPR	LD BE	(X5) COMPLETION DATE
F0328 SS=D	The facility must receive proper traceive processory care and prostneses. Based on observative record review, that humidity to 1 rescannula and to ensuit obstructive respiration), utilities for 1 of 4 resident C-PAP(continuous pressure)/BI-PAI pressure) therapy (Resident #C) Findings include The record of Recond 4/11/12 at 1:2 diagnoses include to respiratory fail apnea and Pickwing hypoventilation services and processive property in the processive proce	nteral fluids; crostomy, or ileostomy care; are; ing; ation, interview and e facility failed to attach ident's oxygen per nasal asure the same resident sleep apnea (cessation of zed her bi-pap at night, ats reviewed for us positive airway? (bilevel positive airway? (bilevel positive airway? in a sample of 5.	F0328	F 328 The facility must that residents receive properties that residents receive properties that residents receive properties; respiratory cannot be discharged to home from facility. 2. All residents woutlibries oxygen with liter flow greater than 2 liters/minute the potential to be affected records of all residents woxygen with a liter flow greater than 2 liters/minute have reviewed to ensure that humidification is being utioned by the physician attachment 1) 3. All nurse in-serviced by the DNS designee by April 27, 201 regards to ensuring humi is being utilized, if ordere physician, if the oxygen list is greater than 2 liters/minute charge nurse will more daily on all shifts to ensure humidification is being us physician order and will dappropriately on the Treat Record. (See attachments)	roper pecial re. 1. en the who ows te have ed. The ho utilize reater been dilized, if (See ses will S or her 12 in diffication d by the ter flow nute. enitor re led per locument ttment	04/27/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 16 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155230	B. WIN			04/12/2012	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		2050 CHESTER BLVD				
ROSEBUD VILLAGE					OND, IN 47374		
(X4) ID		EATEMENT OF DEFICIENCIES			,	(X5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	DATE	
1110		red 15 on the BIMS	+	1710	The DNS or her designee will	BATE	
					monitor all residents daily on		
	,	for Mental Status). The			scheduled days of work, on		
	_	ndicated the resident's			varying shifts, for 4 weeks; the	n 3	
		tact. The MDS indicated			times per week, on varying shi	fts,	
	the resident recei	ived oxygen therapy and			for 4 weeks; then monthly, on		
	BI-PAP/C-PAP t	therapy.			varying shifts for 3 months, the		
					quarterly, on varying shifts, un compliance is maintained for 2		
	Resident #C's ph	ysician's recapitulation			consecutive quarters to ensure		
	-	2, indicated "oxygen at 6			that humidification is being		
	•	izer (oxygen conserving			utilized for those residents who		
	device) and C-PAP with setting of 6 use				have physician's orders for		
	at HS (bedtime)."				humidification, if they are utiliz oxygen at a liter flow greater the		
					2 liters/minute. (See attachme		
	1.) During an ob	oservation on 4/12/12 at			3)To ensure compliance, the audits will be reviewed by the		
		ent #C was in her room,					
	-	wearing oxygen at 6			ent		
	liters nasal cannu				thly		
	inters masar cannic	iia.			Executive Director, at the mon meeting for 6 months or until	,	
	During on interior	iow with Posident #C on			compliance is maintained for 2		
	_	iew with Resident #C on			consecutive quarters.5. The		
		.m. indicated the oxygen			above corrective measures will		
	_	did not have humidity			completed on or before April 2 2012.	1,	
		l it was making her nose			2012.		
		ed "I will be glad when I					
		e my oxygen at home has					
		t does not dry my nose					
	out like this does	j."					
	During an interv	iew on 4/12/12 at 2:00					
	p.m., the ADON (Assistant Director of Nursing) indicated humidity was not						
	•	s's oxygen unless they					
		ns without humidity.					
	in the sympton						
	Mosby's Clinical	Nursing, 5th edition,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 17 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 12/2012
	PROVIDER OR SUPPLIER		STREE 2050	T ADDRESS, CITY, STATE, ZIP CHESTER BLVD IMOND, IN 47374	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		ratory Management, cation with liter flows ers/minute."				
	the following: - 3/31/12 at 2:45 C-PAP tonight, s scared,' resident why she should whows but doesn - 4/8/12 at 1:15 at C-PAP tonight st just her 02 on. 0 liters in place." - 4/9/12 at 1:30 at	a.m., "resident refused stated 'it makes me feel was educated on reasons wear it. She said she 't want it." a.m., "resident refused tating that she is ok with 2 on via nasal cannula 6 a.m., "resident on 6 liters mula, refused C-PAP				
	p.m., Resident #0 indicated Reside problem with the provided and has C-PAP since she The family mem that her C02 (car up or with her slo	iew on 4/11/12 at 3:00 C's family member at #C is having a e C-PAP the facility and been able to use a came into the facility. Beer stated, "I am worried bon dioxide) might build eep apnea she might just om not using the C-PAP				
	a.m., Resident #0	iew on 4/12/12 at 9:30 C indicated she had only e first night she was in				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 18 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		155230	A. BUII B. WIN	LDING		04/12/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		2050 CHESTER BLVD				
ROSEBUD VILLAGE				RICHM	OND, IN 47374		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT PROPERTY PLAN OF CORRECT PLAN OF CORRECT PLAN OF CORRECT PROPERTY PRO			
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ATE	COMPLETION DATE
1.10		use the first night she		0			5.112
	I -	machine from home.					
		ght the facility instructed					
	her to send her C	2-PAP machine home and					
	use the C-PAP m	nachine the facility					
	furnished. She i	indicated the C-PAP					
		lity furnished did not					
		er feel afraid because she					
		she was receiving any					
	1	esident #C stated "I have					
	told the nurses every evening that I can't breathe with that C-Pap and I just can't						
	wear it."	C-1 ap and 1 just can t					
	wear it.						
	During an interv	iew on 4/12/12 at 9:50					
	•	licated Resident #C had					
	refused to wear h	ner C-PAP when she tried					
	to hook the C-PA	AP up at 9:00 p.m., a few					
		eause Resident #C did not					
	_	ing any oxygen. LPN #1					
	stated "I told her	r she was getting					
	oxygen."						
	During an interv	iew on 4/12/12 at 10:45					
	1	icated she was not aware					
		h Resident #C's C-PAP					
	_	old her today, and the					
		ns the C-PAP are					
	coming later toda	ay to check Resident #C's					
	C-PAP machine.						
	T	relates to complaint					
	IN00106389.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet

Page 19 of 20

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING	9 <u>00</u>	COMPLETED 04/12/2012			
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE			
	3.1-47(a)(6)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C9WP11

Facility ID: 000135

If continuation sheet Page 20 of 20